KEMENTERIAN KOORDINATOR
BIDANG KESEJAHTERAAN RAKYAT

INDONESIA NATIONAL HIV/AIDS STRATEGY
2003 - 2007

OFFICE OF THE COORDINATING MINISTER FOR
PEOPLE'S WELFARE/NATIONAL AIDS COMMISSION
2003

FOREWORD

Indonesia has been dealing with the HIV/ AIDS epidemic for 15 years, and, due to the continued presence of several factors that facilitate the transmission of this disease, it is feared that the epidemic will be protracted. Currently, the two most common modes of transmission are unsafe sex and injection drug use. If we are unable to control this disease in the next ten years, it will not only continue to be a grave public health concern but will also have serious and wide-reaching socio-economic implications. The suffering inflicted by HIV/ AIDS is borne not only by those infected with the virus, but by their families and communities as well. No vaccine or cure has yet been found.

The spread of HIV/ AIDS is not just a health problem. It also has political, economic, social, ethical, religious and legal implications, which, sooner or later, will touch all aspects of the life of this nation in real and tangible ways. For this reason, it is a very real threat to this country's efforts to improve the quality of its human resources.

International experience indicates that a successful response to HIV/AIDS very much depends on political will at the highest levels, coupled with committed leadership to tackle this complex problem. This, in turn, must be supported and carried forward by government agencies, NGOs and the private sector.

Although Indonesia has already made great efforts to control HIV/ AIDS, the results are still far from satisfactory. Education and outreach based on religious and cultural norms have been complemented by public health interventions, including prevention activities, treatment of sexually transmissible infections, and treatment, care and support for people living with HIV/ AIDS (PLHA).

Prevention efforts, carried out through public education and outreach, have so far been aimed principally at vulnerable populations from and among which the disease can easily be spread. Treatment and care interventions have been both clinic-based and community-based, but will need to be expanded in anticipation of growing numbers of PLHA.

One of the major constraints is funding. This obstacle could be overcome by promoting multisectoral coordination among all the agencies involved in HIV/ AIDS prevention. And with regional autonomy now a reality, local governments also have a key role to play in HIV/ AIDS prevention by ensuring that sufficient funds are allocated to tackle the problem at the local level.

The National HIV/ AIDS Strategy is intended as a guideline, for all government sectors, local governments, NGOs, the private sector and the world of work, on controlling HIV/ AIDS in Indonesia. Program executors can further develop the strategies and activities set forth here according to their respective tasks, functions and capabilities.

My thanks go to everyone who assisted in the preparation of the National HIV/ AIDS Strategy 2003 - 2007.

Coordinating Minister for People's Welfare/
Chairman of the National AIDS Commission

M. Jusuf Kalla

EXECUTIVE SUMMARY

The first National HIV/ AIDS Strategy was formulated and put into action in 1994. A number of recent developments have prompted the government to revise this Strategy.

Epidemiological data show clearly that the spread of HIV in Indonesia since 1995 has become increasingly serious, with a drastic increase in the number of new cases of people infected with HIV.

HIV prevalence in donor blood has increased 8 times since 1995, while in several areas prevalence among sex workers is approaching 5%.

In Indonesia, there is already a concentrated epidemic in certain provinces, such as Riau, Papua, DKI Jakarta and Bali. As of 2002, a total of 29 provinces had reported cases of HIV.

HIV transmission through sexual intercourse accounts for the highest number of new infections, followed by transmission through needles shared by injecting drug users, which has shown a dramatic eightfold increase in the last 6 years. Commensurate with the increase in the number of people testing positive for HIV, the number of AIDS cases has also risen sharply, meaning that the response to the disease needs to cover not just prevention but also treatment, care and support. At the same time, although antiretroviral drugs are proliferating, access to them is still very difficult, partly because they are still very expensive, but also because specific clinical measures are required in their use and supervision.

Though a variety of initiatives have been undertaken to reduce stigma and discrimination against PLHA and their families, such prejudice continues. One way to overcome it is to raise awareness and understanding of HIV/AIDS in various sectors of society, including among those who work in the health services.

The national response to HIV/ AIDS reflects Indonesia's participation in fulfilling international commitments, specifically the resolutions set forth in the UNGASS and ASEAN Declarations on HIV/ AIDS in 2001. HIV/ AIDS was also discussed in a special cabinet session in March 2002. In this context, a greater role for PLHA needs special consideration.

Based on comprehensive review of the literature and extensive consultation with related parties and specialists, seven program priority areas for the next 5 years have been identified:

1. HIV/ AIDS Prevention
2. Care, Treatment and Support for PLHA
3. HIV/ AIDS and STI Surveillance
4. Operational Studies and Research
5. Enabling Environments
6. Multi-stakeholder Coordination
7. A Sustainable Response

This National Strategy sets forth the principles of the HIV/ AIDS response as the primary reference or guidelines for everyone involved in HIV/AIDS prevention and control.

These principles include:

1. Take religious and cultural values and social norms into account, and strive to maintain and strengthen family welfare and cohesion.
2. Give due attention to the vulnerable sectors of society, including marginalized groups.
3. Respect human rights and give due attention to justice and gender equity.
4. Prioritize prevention through information, education and communication (IEC) and the use of other effective methods.
5. Promote multi-stakeholder involvement based on the principle of partnership, with the government taking a steering and guiding role.
6. Treat HIV/ AIDS as a social concern.
7. Ensure that the response is firmly based on scientific facts and data.

The roles and responsibilities of the parties involved are clearly presented and reflect, among other things, the significant roles played by executors at regional level, including the House of Representatives and Regional Legislative Councils, non-government and community-based organizations, and the private sector/ business community.

The need for strong leadership and consensus, as well as coordination at all levels in the control of HIV/ AIDS, is absolute.

The goals set forth in this National Strategy will not be accomplished unless the effort is carried out seriously, systematically, consistently and through clear mechanisms.

The processes undertaken in the response must be monitored and evaluated using appropriate and measurable performance indicators. Because HIV/ AIDS prevention is an integral part of Indonesia's development, the relationship between the National HIV/AIDS Strategy and national strategies in other sectors must be taken into account.

The HIV/ AIDS response involves considerable costs. Therefore, responsibility for funding must be assumed jointly by the government and the community, taking into consideration not only the principle of regional autonomy but also the magnitude of the problem.

Foreign aid which is non-binding and provides clear benefits is still needed, but it must be borne in mind that such assistance will eventually diminish. We must, therefore, be prepared to strengthen our own self-reliance.

CONTENTS

Foreword
Executive Summary
Contents

INTRODUCTION
1. HIV/ AIDS in Indonesia 1987 - 2002
2. The Response to HIV/ AIDS
3. Socio-economic Impacts

THE NATIONAL HIV/ AIDS STRATEGY
1. The Amendment of the 1994 National HIV/AIDS Strategy
2. Goals of HIV/ AIDS PREVENTION
3. HIV/AIDS Prevention Policy

PRIORITY AREAS FOR HIV/ AIDS RESPONSE
1. HIV/ AIDS Prevention
2. Care, Treatment and Support for PLHA
3. HIV/ AIDS and STI Surveillance
4. Operational Studies and Research
5. Enabling Environments
6. Multi-stakeholder Coordination
7. A Sustainable Response

PARTNERSHIPS, ROLES AND RESPONSIBILITIES
1. Central Government
2. Provincial Government
3. District/ Municipal Government
4. Subdistrict Government
5. Ward/ Village Government
6. The House of Representatives and Regional Legislative Councils
7. The National AIDS Commission
8. Provincial and District/ Municipal AIDS Commissions
9. Community-Based and Non-governmental Organizations
10. Private Sector/ Business Community
11. Professionals, Professional Organizations and Educational Institutions
12. The Community
13. People Living With HIV/ AIDS (PLHA)

INTERNATIONAL COOPERATION
IMPLEMENTATION OF THE NATIONAL STRATEGY
MONITORING AND EVALUATION
FUNDING
CONCLUSION

Annex 1: Diagram Departmental and Non-departmental Roles and Responsibilities on HIV/ AIDS

Annex 2: Abbreviations and Technical Terms

BIBLIOGRAPHY

AD-HOC TEAM THE DEVELOPMENT OF NATIONAL HIV/AIDS STRATEGY: 2003-2007

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a set of symptoms caused by the Human Immunodeficiency Virus (HIV). This virus damages the body's immune system, reducing its resistance to infection and illness.

HIV is found in body fluids, especially semen, vaginal fluids and blood. Transmission generally occurs through unprotected sexual intercourse, blood transfusions use of unsterilized needles, organ transplants, and from mothers to their babies during pregnancy or at birth.

By 2002 some 42 million people all over the world had been infected with HIV and 21.8 million of them had died as a result of AIDS. Most of those infected were young people, reflecting the fact that this disease is strongly linked to lifestyle, and to sexual behaviour and injection drug use in particular.

Indonesia is among the Asian countries experiencing an HIV/ AIDS epidemic where prevalence is escalating rapidly and showing no signs of slowing down, despite efforts to control HIV/ AIDS on behalf of the community, NGOs and the private sector as well as the government.

1. HIV/AIDS IN INDONESIA 1987 - 2002

Since 1987, there have been worrying developments in HIV/ AIDS in Indonesia in terms of numbers and mode of transmission. Three distinct periods can be identified in the development of HIV/ AIDS policy.

1.1. 1987 - 1994

The first case of AIDS in Indonesia was identified in a foreign male in Bali, who subsequently died in April 1987. The first reported death from AIDS of an Indonesian was in Bali in June 1988. At that point, the HIV problem in Indonesia began to attract attention, but this as still largely confined to health circles.

Blood tests carried out in several provincial capitals around 1990 indicated that HIV infection had spread to several provinces, although prevalence was still low. Blood test results of some 10,500 donors proved to be negative; indications that HIV infection was on the rise in Indonesia only started to surface when tests of donor blood in 1992/ 1993 showed that 2 out of every 100,000 donors were HIV positive, rising to 3 per 100,000 in 1994/ 1995.

1.2. 1994 - 2002

HIV transmission in Indonesia has escalated sharply since 1995. This is reflected in the increase in the number of blood donors testing positive for HIV: rising from 3 per 100,000 in 1994 to 4 per 100,000 in 1998/ 1999, this figure then leapt to 16 per 100,000 in 2000, meaning that there has been an eightfold increase in the last 10 years.

In 2000, the HIV epidemic underwent a change: a significant increase in HIV was detected among sex workers (SW), and variations became apparent from one region to another. In Tanjungbalai Karimun in the province of Riau, for example, where prevalence was only 1% in 1995/ 1996, it had risen to more than 8.38% by 2000. Meanwhile, HIV prevalence among SW in Merauke, Papua, reached 26.5%; in North Jakarta, 3.36%; and in West Java, 5.5%.

In the same year, HIV infections were reported in nearly all provinces in Indonesia. Although HIV prevalence in the general population was still low, Indonesia was categorized as a country with a concentrated epidemic because there were pockets where prevalence in certain subpopulations exceeded 5%.

A new phenomenon in HIV/ AIDS transmission appeared in 1999 when HIV began to be detected in injecting drug users. The practice of sharing needles among injecting drug users (IDUs) allows HIV to spread very rapidly. In 1999, 18% of IDUs being treated at the Drug Dependency Hospital -Jakarta were infected with HIV, and this increase to 40% in 2000 and 48% in 2001. Meanwhile, 90% of the IDUs in Kampung Bali, Jakarta, were discovered to be infected with HIV in 2000.

Overall, between 1996 and 2002, the number of HIV cases increased by almost 17.5%. While in 1996 only 2.5% of AIDS cases were caused by injection drug use, this figure had increased to 20% by 2002.

From all the data collected, it appears that more men have been infected with HIV than women. However, in 2000 very high HIV prevalence was detected in female sex workers in Merauke (26.5%) and in Tanjung Balai, Karimun (8%). In the 16 years up to the end of 2002, 1016 AIDS cases were reported. This figure, however, is just the tip of the iceberg: actual prevalence is far higher. In 2002 it was estimated that the real number of people infected with HIV was somewhere between 90,000 and 130,000.

1.3. Future Trends

The increase in HIV infection in Indonesia is set to continue over the next 5 years as people increasingly engage in unprotected sex and the spread of HIV through injection drug use accelerates. It is feared that new epidemics will emerge and the number of AIDS cases being treated will multiply. The number of deaths from AIDS among people still in their productive years will escalate.

Although a range of antiretroviral medications (ARV) are increasingly available, their high cost makes them inaccessible to most. Policies on the supply, distribution and proper use of ARV, however, are becoming clearer.

Stigmatisation and discrimination against people with HIV/ AIDS is still widespread, although due to a growing awareness and understanding of HIV/ AIDS among the public, this has begun to diminish in relative terms.

2. THE RESPONSE TO HIV/ AIDS

Some time after the outbreak of the HIV/ AIDS pandemic in 1981, WHO warned all countries to take measures to respond to this devastating epidemic that presents such a grave threat to human life. Indonesia's response was strongly influenced by the growing knowledge about HIV/ AIDS and its determining factors, as well as the resources available.

2.1. 1985 - 1989

In 1985, the National Institute For Research and Development, MOH formed a working group which was tasked with monitoring the global development of HIV/ AIDS, particularly its progression in Southeast Asia, and to gather information on the epidemiology of HIV/ AIDS. In 1988 the Minister of Health established a Working Group on HIV/ AIDS prevention, and this was reorganized and expanded in 1989 by bringing in multisectoral and NGO representatives as members. The Working Group's primary task was to manage communication and coordination, as well as to gather and disseminate information to alert all sectors to the problem of HIV/ AIDS.

In 1988 the Ministry of Health issued a regulation making it mandatory to report all cases of AIDS, and appointing certain laboratories to carry out HIV testing. Various guidelines and manuals were developed and distributed for information, education and communication purposes.

2.2. 1989 - 1994

The HIV/ AIDS response initially began with HIV surveillance in certain subpopulations-such as sex workers-and the screening of donor blood by the Blood Transfusion Unit of the Indonesian Red Cross (PMI). The number of laboratories with HIV testing facilities was increased to enable all provincial health laboratories to participate in HIV/ AIDS surveillance. Capacity building for health workers on HIV/ AIDS was effected through education and training programs, and several officials from both health and non-health sectors were sent abroad for further training and experience.

Information, education and communication (IEC) on HIV/AIDS was intensified through seminars for journalists, medical faculty staff, the private sector and the business community. A range of IEC aids, including books, brochures and leaflets, were published, reproduced and distributed. Growing numbers of NGOs concerned with AIDS reflected a growing awareness within the community of the part they could play in HIV/ AIDS prevention.

The National AIDS Commission (KPA) was established by virtue of Presidential Decree Number 36/ 1994, and was chaired by the Coordinating Minister for People's Welfare. The Commission published a National AIDS Prevention Strategy as well as various other edicts.

2.3. 1994 - 2002

Regional AIDS Commissions (KPAD) were established in every province and district. AIDS NGOs also flourished and they are now established in almost every province in Indonesia. Many of them are implementing very intensive and specific programs on, for example, counseling, IEC, education, training, treatment, and care. Spiritual leaders from all different religions are also playing a part in prevention activities.

Both the AIDS Commission and a number of Ministries and related sectors have formed working groups on AIDS prevention in line with the scope of their operations.

Bilateral, regional and international cooperation efforts have also got underway. Several international organizations, including WHO, UNAIDS, UNICEF, UNFPA, UNDP, the World Bank and the Asian Development Bank, have provided technical assistance and funding. Bilateral aid has come from the United States of America, Australia, Germany and Japan, among others. Indonesia has also participated in both regional and international meetings on HIV/ AIDS prevention, and much of the output of these discussions has been adopted and incorporated into Indonesia's HIV/ AIDS prevention policy.

3. SOCIO-ECONOMIC IMPACTS

Empirical experience in a number of countries where HIV/ AIDS is widespread shows that there are troubling socio-economic impacts. Economic losses result from the burden caused by the high costs of testing, treatment and care that must be borne directly by the families and the community. Indirect economic losses have also arisen as a result of the decreasing productivity and rising death rates among people of productive age due to AIDS. Poor families and communities have been pushed deeper into poverty as a result of the suffering caused by HIV/AIDS. Children are orphaned by the deaths of their parents from AIDS. They then experience prolonged social distress as a result of the loss of family and community support.

A further consequence is the stigma associated with people with HIV/AIDS and their families, and the discrimination and violations of their human rights they suffer as a result. Discrimination is still common in health centres, schools, workplaces and even in many aspects of daily life in the community.

1. THE AMENDMENT OF THE 1994 NATIONAL HIV/AIDS STRATEGY

The first National HIV/ AIDS Strategy was formulated in 1994. A number of recent developments and changes have prompted the government to revise this Strategy.

Some of the most important justifications for amending the National Strategy are as follows:

1.1. Changes in the HIV/ AIDS epidemic and modes of transmission HIV prevalence is increasing, and in certain subpopulations in several areas it is becoming a concentrated epidemic. Since 1999 injection drug use has begun to emerge as a more frequent route of transmission than sexual intercourse.

1.2. Developments methods of controlling HIV/AIDS.

The discovery of antiretroviral drugs (ARV) in the last 5 years has the potential to improve quality of life for people living with HIV/AIDS (PLHA). Methods of controlling HIV/ AIDS that have proved to be effective, such as IEC, 100% condom use and harm reduction for IDUs, need to be prioritised.

1.3. Changes in the structure of government Since 2001 governance has shifted from a centralised to a decentralised model, transferring much of the authority for both the execution of and providing budgets for HIV/ AIDS prevention to the district and municipal administrations.

1.4. Internationally binding resolutions Various new international agreements, primarily the Declaration of Commitment of the 2001 United Nations General Assembly Special Session on HIV/ AIDS (UNGASS), have prompted Indonesia to adjust not only its HIV/ AIDS prevention methods but also its achievement targets.

2. GOALS OF HIV/ AIDS PREVENTION

2.1 General Goals of HIV/ AIDS Prevention To prevent and limit the spread of HIV, to improve the quality of life of PLHA and to alleviate the socio-economic impacts of HIV/ AIDS.

2.2. Specific Goals of HIV/ AIDS Prevention

2.2.1. To provide and disseminate information and to create a supportive environment for HIV/ AIDS prevention, with an emphasis on prevention among high-risk populations and the people with whom they interact.

2.2.2. To provide care, treatment, support and counseling to PLHA and to integrate this with prevention efforts.

2.2.3. To enhance the role of young people, women, families, and the wider community, including PLHA, in a range of HIV/AIDS prevention initiatives.

2.2.4. To create and foster partnerships between government agencies, NGOs, the private sector and the business community, professional organizations, and national and international donor agencies, both in the centre and in the regions, to step up the national response to HIV/ AIDS.

2.2.5. To improve the coordination of national and regional policies and initiatives on HIV/ AIDS prevention.

3. HIV/ AIDS PREVENTION POLICY

The transmission and spread of HIV/ AIDS is closely linked to risky behaviour. For this reason prevention must take into consideration the factors that influence such behaviour.

HIV/ AIDS control efforts can be differentiated on the basis of the groups they target-that is, low-risk behaviour groups, high-risk behaviour groups and PLHA. Each group calls for a different approach. For PLHA, for example, an approach that is limited to IEC will have limited results; it must be supported by complementary initiatives such as care and treatment.

With this conceptual background, HIV/ AIDS prevention policy in Indonesia has been formulated on the following principles:

3.1. HIV/AIDS prevention must take into account religious and cultural values and social norms, and activities must be aimed at upholding and strengthening family welfare and cohesion.

3.2. HIV/AIDS prevention efforts should be implemented by the community, the government and NGOs on a partnership basis. The community, together with NGOs, should be the leading agents while the government takes responsibility for steering, guiding and creating a conducive atmosphere to support HIV/ AIDS prevention.

3.3. Prevention must be based on the understanding that HIV/ AIDS is a national issue that needs to be tackled through a national response.

3.4. HIV/AIDS prevention efforts must give due attention to the vulnerable sectors of society, including those belonging to marginalized groups and those whose work puts them at risk of exposure to HIV/ AIDS.

3.5. HIV/ AIDS prevention efforts must respect the dignity and rights of PLHA and their families, and take gender equality and justice into consideration.

3.6. Efforts to prevent HIV transmission should be carried out through Information, Education and Communication (IEC) aimed at promoting a healthy lifestyle.

3.7. Effective prevention efforts include 100% condom use for sex workers, their clients and partners of PLHA, and "double protection" condom use in families.

3.8. Harm reduction activities should be employed to reduce HIV infections among injecting drug users.

3.9. HIV/AIDS prevention should be an integrated response aimed at promoting healthy behaviour, preventing illness, improving treatment and care based on scientific facts and data, and providing support for PLHA.

PRIORITY AREAS FOR HIV/ AIDS RESPONSE

Based on a comprehensive review of the literature and extensive consultation with related parties and specialists, seven program priority areas have been identified:

1. HIV/ AIDS Prevention
2. Care, Treatment and Support for PLHA
3. HIV/ AIDS and STI Surveillance
4. Operational Studies and Research
5. Enabling Environments
6. Multi-stakeholder Coordination
7. A Sustainable Response

1. HIV/ AIDS PREVENTION

HIV/ AIDS is both a health problem and a social problem. Because the spread of HIV/ AIDS is strongly influenced by human behaviour, any efforts to prevent it need to take this factor into consideration.

Prevention efforts among the general population consist of improving skills and knowledge, in ways appropriate to local religious and cultural norms, about how the virus is transmitted, its consequences and how to prevent it, using existing IEC methods.

Disseminating knowledge through formal and non-formal education as well as through religious channels is achieved by systemically integrating HIV/ AIDS materials into the regular curriculum. This requires capacity building for teachers, tutors, trainers, bureaucrats and leaders of work units, who can pass such information on to their students or subordinates.

Proper implementation of an IEC program also calls for capacity building for those on the front line-health workers, social workers, outreach workers, teachers, master trainers and so on.

Prevention efforts directed at high-risk populations such as sex workers and their clients, PLHA and their partners, IDUs, and others who, due to the nature of their work, are at risk of being infected with HIV/ AIDS should be based on effective prevention measures such as condom use, harm reduction, observance of universal precautions and so on.

Working on this conceptual basis, the following target groups need to be defined:

Vulnerable groups

Vulnerable groups are groups of people who, because of the nature of their work, their environment, low level of family support and welfare, or health status, are vulnerable to HIV. These groups may include highly mobile people, women, youth, street children, poor people, pregnant women, and blood transfusion recipients.

Infection-risk groups

Infection-risk groups are groups of people who are linked to high-risk behaviour, such as sex workers and their clients, injecting drug users, and people detained in correctional/detention centres.

Infected groups

People in this group are already infected with HIV (PLHA) who need a special approach because of their potential to transmit the disease to others.

1.1. Goal

The goal of all prevention programs is to ensure that everyone can protect themselves against HIV infection, and avoid transmitting the virus to others.

1.2. Activities

The activities that can be carried out to achieve this goal are as follows:

1.2.1. Intensify Information, Education and Communication

Improving knowledge, changing attitudes and promoting positive behaviour to prevent transmission.

1.2.2. Reduce vulnerability

This can be achieved by improving education, economic status and gender equality.

1.2.3. Increase condom use

Promoting the use of condoms at every risky sexual encounter as a means of preventing HIV and STI infection.

1.2.4. Increase the supply of safe blood

All donor blood must be screened for HIV because of the extremely high risk of transmission through transfusion. Every district/ municipality should therefore be equipped with a blood transfusion unit that can provide safe blood.

1.2.5. Step up efforts to reduce the prevalence of sexually transmissible infection.

Because STI patients have a 2- 9 times greater risk of being infected with HIV than people who do not have STI, efforts to test for and treat such infections must be stepped up.

1.2.6. Improve measures to prevent mother-to-child transmission.

Use of ARV during pregnancy, safe birthing procedures and the use of breast milk substitutes can all help to prevent mother-to-child transmission.

1.2.7. Improve the application of universal precautions.

Universal precautions must be strictly observed by everyone who could be directly exposed, such as medical officers and paramedics, social workers, police officers/detectives, undertakers, field workers and so on. For this reason, they must be given the knowledge, skills and facilities to enable them to prevent transmission.

1.2.8. Step up efforts to prevent HIV transmission among injecting drug users.

Sharing needles can transmit HIV directly into the bloodstream. Efforts to prevent this through harm reduction should be based on a national-level inter-sectoral agreement between, inter alia, the National AIDS Commission, the Ministry of Health, the National Narcotics Board, Police Department, the Ministry of Justice and Human Rights, the Ministry of Social Welfare, the Ministry of Education, the Ministry of Religious Affairs, and NGOs.

2. CARE, TREATMENT AND SUPPORT FOR PLHA

One of the most important outcomes of the UN General Assembly Special Session on HIV/ AIDS (UNGASS) in 2001 was the agreement on the need to expand care and support services for PLHA and to ensure protection of their basic human rights (to prevent, reduce and eliminate stigma and discrimination).

Care, treatment and support for PLHA can be extended both through a clinical approach and through community and home-based care, as well as by supporting the establishment of PLHA support groups.

2.1. Goal

To alleviate the suffering caused by HIV/ AIDS and prevent further HIV infections, and to improve the quality of life of PLHA.

2.2. Activities

The activities that can be carried out to achieve these goals are as follows:

2.2.1. Intensify advocacy to decision makers concerned with the provision of health services and drug supply.

2.2.2. Improve education and training for those involved in care, treatment and support for PLHA; counseling training and increase the number of professionals and volunteers-including PLHA-for care, treatment and support.

2.2.3. Make high quality care, treatment and support available for PLHA.

2.2.4. Improve the procurement, distribution and use of guidelines on care, treatment, support, counseling and create specific models of care for men, women and children.

2.2.5. Develop the infrastructure for health services, voluntary counseling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), care for PLHA and community and home-based care, and provide support for the establishment of PLHA support groups.

2.2.6. Improve PLHA access to high quality of healthcare, including pricing is more affordable, high quality antiretroviral drugs and medications to treat opportunistic infections.

3. HIV/ AIDS AND STI SURVEILLANCE

Data collection through systematic and continuous surveillance plays a key role in HIV/AIDS prevention by providing information on the distribution and trends of HIV infection, the distribution of AIDS cases and other factors that influence the spread of HIV in the community.

Apart from providing insights into the scope, trends and distribution of HIV/AIDS, epidemiological and behaviour surveillance also yield important information for planning a response that covers prevention, care, treatment and support for PLHA, capacity building, research, legal reform and development and other activities.

HIV/AIDS surveillance is the collection, processing and analysis of HIV/AIDS data, together with the dissemination of the results, with the intention of improving the implementation of the response to the disease.

HIV/ AIDS surveillance in Indonesia began in 1988 with the enforcement of mandatory reporting of AIDS cases which was followed by the phasing in of HIV surveillance.

Since HIV transmission is linked to unsafe sexual behaviour and injection drug use, behavioural surveillance surveys are needed to ensure early detection of the rate of HIV transmission and to anticipate the existence of vulnerable groups.

STI is a public health concern which, because it is endemic in Indonesia, facilitates the spread of HIV. For this reason, STI surveillance and monitoring HIV prevalence in STI patients is a necessary part of HIV/AIDS prevention efforts.

For proper HIV, AIDS and STI surveillance, good laboratories are needed in sufficient number in each region, supported by a network of diagnostic laboratories and referral laboratories. This calls for a standardized surveillance system with national coordination and direction from the Ministry of Health.

3.1. Goal

To obtain information on the magnitude, distribution and trends of HIV/ AIDS and STI transmission, which can be used in formulating HIV/ AIDS prevention policy and activities.

3.2. Activities

The activities that can be carried out to achieve this goal are as follows:

3.2.1. Improve the reporting of AIDS and HIV cases Ensure regular reporting of cases of AIDS and HIV infection in provinces, districts and municipalities, and places providing services.

3.2.2. Intensify HIV surveillance Increase HIV surveillance in population groups at various levels of risk of transmission in several places, including border areas and conflict areas, to detect the probability of HIV transmission. HIV surveillance should be unlinked and anonymous.

3.2.3. Intensify behavioural surveillance

Increase surveillance through systematic surveys that comply with behavioural surveillance ethics.

3.2.4. Intensify STI surveillance

Increase STI surveillance in population groups with various levels of risk.

3.2.5. Develop laboratories

Upgrade laboratories to support HIV, AIDS and STI surveillance as well as for diagnostic purposes, and develop a network of referral laboratories.

4. OPERATIONAL STUDIES AND RESEARCH

Operational studies and research are needed to provide a basis on which to determine HIV/ AIDS policies in light of changes in the epidemic and its impacts.

Existing studies are still very limited in number and scope, and for the most part have concentrated on HIV prevalence in high-risk behaviour groups. Studies on other aspects of HIV/ AIDS, for example on medicinal raw materials that can be found in Indonesia, could influence or even help to slow the progression of the disease.

In addition, research into the socio-economic impacts of the epidemic should be carried out at regular intervals.

To build research capacity, cooperation should be fostered between local, national and international research institutes.

4.1. Goals

To carry out operational studies and research to get information that will help to improve the quality of HIV/ AIDS prevention programs, as well as to mitigate some of the negative impacts of HIV infection on individuals and the community, and improve the quality of life of PLHA.

4.2. Activities

The activities that can be carried out to achieve these goals are as follows:

4.2.1. Epidemiological and behavioural studies

Research into the epidemiological, behavioural and socio-cultural factors that influence the spread of HIV.

4.2.2. Clinical management studies

Studies on the benefits and safety of new treatments and clinical strategies, and on resistance to the drugs used to treat AIDS, STI and opportunistic infections.

4.2.3. Studies on raw materials for traditional remedies

Research to discover raw materials in Indonesia for traditional remedies to complement clinical treatment.

4.2.4. Studies on care management

Research into community-based care to seek the most appropriate approach for PLHA.

4.2.5. Studies on the social impact of HIV/ AIDS

Research into the impact of the HIV/AIDS epidemic on the socio-economic condition, not only of PLHA, but also of the wider community.

4.2.6. Operational research

Operational research to provide input for the design of new approaches to HIV/ AIDS prevention, including 100% condom use for sex workers and their clients and harm reduction programs to control HIV transmission among IDUs.

4.2.7. Improving research capacity

Building capacity for research on HIV/ AIDS and associated infections at national, provincial and district/ municipal levels.

4.2.8. Strengthening research networks

Increasing cooperation between centres of HIV/AIDS research at local, national and international levels to exchange information and research results.

5. ENABLING ENVIRONMENTS

The UNGASS Declaration resolved that by 2003, regulations and other provisions would be ratified, supported or enforced as law to eliminate all forms of discrimination and confirm the basic human rights and freedoms of PLHA and members of vulnerable groups.

Stigma, discrimination, and human rights violations are still apparent in spite of attempts to dismantle prejudice through information, education and communication. Moreover, there are still many aspects of HIV/ AIDS prevention that are not adequately supported by legislation. As a result, prevention initiatives are frequently met with impediments.

Supportive environments for the reduction of stigma, discrimination and human rights violations and the removal of such impediments to HIV/AIDS prevention efforts are urgently needed.

5.1. Goal

To pass legislation that will create an environment that fully supports the implementation of HIV/ AIDS prevention.

5.2. Activities

The activities that can be carried out to achieve this goal are as follows:

5.2.1. Study and drafting of legal instruments

To make a study of the existing legislation and to draft new laws and regulations needed to support HIV/AIDS prevention.

5.2.2. Advocacy

Advocacy to the Government and the House of Representatives to pass legislation to create an enabling environment in order to eradicate the stigma, discrimination and human rights violations that occur in the provision of service to PLHA and their families, as well as regulations to support specific prevention programs such as 100% condom use and harm reduction.

5.2.3. Improve civil service capacity
Build capacity among officials at each administrative level of government to eliminate discriminatory practices and attitudes, as well as violations of human rights, in the provision of services to PLHA and their families.

5.2.4. Conduct outreach activities
Conduct outreach activities to the community to break down stigma and to eliminate discrimination and human rights violations against PLHA and their families.

6. MULTISTAKEHOLDER COORDINATION
The existence of HIV/ AIDS in the community is influenced by a collection of factors including behaviour, level of education, and poverty. The impacts are far-reaching, even affecting the socio-economic condition of both the communities and the families hit by HIV/ AIDS. Poor families are forced deeper into poverty and become unproductive, and discrimination and human rights violations begin to emerge along with prolonged physical and mental suffering. For this reason, HIV/AIDS must be handled in a coordinated fashion by government, the private sector/business community and NGOs. This coordination needs to cover all aspects of planning, funding, organization, monitoring and evaluation.
HIV/ AIDS prevention is coordinated by the National AIDS Commission, Provincial AIDS Commissions and District/ Municipal AIDS Commissions.

6.1. Goal
To harmonize and integrate the HIV/ AIDS prevention policies and activities of government agencies, the private sector/ business community, NGOs, and the community in order to be able to achieve the desired objectives effectively and efficiently.

6.2. Activities
The activities that can be carried out to achieve this goal are as follows:

6.2.1. Enhance the role of the AIDS Commissions
Improve the capacity of the National, Provincial and District/Municipal AIDS Commissions to perform their HIV/ AIDS prevention tasks and functions.
Existing AIDS Commissions will need to be revitalized, while provinces and districts without such commissions should be encouraged to establish them as soon as possible.

6.2.2. Develop strategic plans
Strategic plans for HIV/ AIDS prevention should be drawn up with the participation of all related parties in the stakeholder environment. These should be translated into annual plans.

6.2.3. Build information networks
Build strategic, multiparty HIV/ AIDS information networks to allow for more effective coordination of policy, planning, budgeting and implementation.

6.2.4. Coordinate at national level
Ensure regular communication between all stakeholders through regular and ad hoc meetings of institutions at central, provincial, district and municipal levels, as well as through national meetings.

6.2.5. Coordinate at international level
Coordinate with international agencies to ensure that their resources can be used in an efficient and directed manner.

7. A SUSTAINABLE RESPONSE
In the coming years, the HIV/ AIDS problem confronting Indonesia will grow both in magnitude and complexity. A sustainable response must therefore be guaranteed and intensified to ensure that the goals of HIV/AIDS prevention can be accomplished. Any weaknesses in either the organizations or the individual capacities of all those involved in HIV/AIDS prevention must be overcome through capacity building.
High commitment and strong leadership at all administrative levels must be continually maintained and fostered so that it can be a source of motivation and inspiration for all those involved in HIV/AIDS prevention.
Reliable data and accurate information on all aspects of HIV/AIDS are needed by all parties, including the mass media.

7.1. Goal
To guarantee a sustainable response to HIV/ AIDS at all levels of administration through high commitment and strong leadership, with the information and resources to support it.

7.2. Activities
The activities that can be carried out to achieve this goal are as follows:

7.2.1. Advocacy
Advocate to all parties at every level of administration for high commitment and strong leadership in the prevention of HIV/ AIDS.

7.2.2. Education and training
Conduct education and training programs on all aspects of HIV/AIDS prevention for everyone involved, including volunteers.

7.2.3. Improve facilities
Increase the number and the quality of facilities required for HIV/AIDS prevention.

7.2.4. Funding
Develop funding mechanisms at all administrative levels, including national fundraising.

7.2.5. Set up HIV/ AIDS Data and Information Centres
Provide support for the National, Provincial and District/Municipal AIDS Commissions to serve as HIV/ AIDS Data and Information Centres.

PARTNERSHIPS, ROLES AND RESPONSIBILITIES
The success of HIV/ AIDS prevention efforts in Indonesia is contingent upon cooperation between all parties involved-the government, including the House of Representatives; NGOs; the private sector; the business community; the general public; and PLHA. This cooperation should be founded and pursued on the principle of partnership.
The most important role for the government is to provide strong leadership at every level of governance. Active participation can then come from all stakeholders and the wider community.
In general, the division of tasks and responsibilities is as follows:

1. CENTRAL GOVERNMENT
The Office of the Coordinating Minister for People's Welfare, through the National AIDS Commission, coordinates prevention policy and activities at national level. Each related agency at central level is required to establish a working group on HIV/AIDS prevention and to draw up a plan that is consistent with the National HIV/ AIDS Strategy within the scope of the agency concerned, and to prepare the necessary resources, particularly human resources and funds (Annex 1 shows the roles and responsibilities of ministries and government agencies).

2. PROVINCIAL GOVERNMENT
HIV/ AIDS prevention efforts in provinces are led by the Governor, with active participation from government agencies, non-governmental organizations and educational institutions.
The Provincial government establishes and puts into action a Provincial AIDS Commission and allocates resources, especially human and financial resources, for prevention activities at the provincial level.
Each related agency at the province level is required to draw up a prevention plan that is consistent with the Provincial AIDS Strategy within the scope of the agency's activities.

3. DISTRICT/ MUNICIPAL GOVERNMENT
HIV/AIDS prevention efforts in districts/ municipalities are led by the Regent or Mayor, with active participation from government agencies, non-governmental organizations, education institutions and community leaders.
The District/ Municipal Government establishes and puts into action a District/ Municipal AIDS Commission and allocates resources, especially human and financial resources, for prevention activities at the district/municipal level.
Each related agency at the district/ municipal level is required to draw up a prevention plan that is consistent with the District/Municipal AIDS Strategy within the scope of the agency's activities.

4. SUBDISTRICT GOVERNMENT
HIV/ AIDS prevention efforts in subdistricts are led by the Head of the Subdistrict, who cooperates with the related sectors and nongovernmental and community-based organizations, as well as local communities affected by or concerned with AIDS.

5. WARD/ VILLAGE GOVERNMENT
The Ward or Village Head plays an important role in leading the implementation of HIV/AIDS prevention initiatives in the ward or village.

6. THE HOUSE OF REPRESENTATIVES AND REGIONAL LEGISLATIVE COUNCILS
The House of Representatives and the Regional Legislative Councils at Provincial and District/ Municipal levels have a high degree of awareness and concern of the HIV/ AIDS situation in the areas they govern. In accordance with their mandate, they support prevention efforts by passing legislation, allocating budgets and monitoring the implementation of HIV/ AIDS programs.

7. THE NATIONAL AIDS COMMISSION
The National AIDS Commission, as the agency responsible for the success of HIV/AIDS prevention in Indonesia, needs to be given clearly defined authority to enable it to execute its principal tasks and functions effectively. The AIDS Commission is structured to allow for the involvement of agencies from outside the government, including NGOs and CBOs, while leadership remains in the hands of the government.
The principal tasks and functions of the National AIDS Commission are as follows:

7.1. To formulate and develop a national HIV/ AIDS policy and strategy.
7.2. Policy advocacy to the executive and legislative branches of government to gain support for the HIV/AIDS program.
7.3. To coordinate HIV/ AIDS prevention efforts nationally towards the achievement of prevention goals, through a series of meetings, both scheduled and ad hoc.

7.4. To draft and/ or make a study of the regulations, guidelines, and other legal aspects needed in HIV/ AIDS prevention.

7.5. To develop an information centre on the HIV/ AIDS prevention program.

7.6. To collaborate with the UN System, donor agencies and other international agencies on the prevention of HIV/ AIDS.

7.7. To raise funds from various sources, both national and international, for HIV/ AIDS prevention.

7.8. To provide technical guidance on HIV/ AIDS prevention to related agencies at the central level, to Provincial AIDS Commissions and to District/Municipal AIDS Commissions.

7.9. To monitor and evaluate the implementation of the National HIV/AIDS Strategy and take follow-up action where necessary.

8. PROVINCIAL AND DISTRICT/MUNICIPAL AIDS COMMISSIONS
The Provincial, District and Municipal AIDS Commissions, which are responsible for the coordination of HIV/ AIDS prevention in provinces, districts and municipalities, must be given clearly defined authority. The structure of the AIDS Commissions includes agencies from outside the government, including NGOs and CBOs, while leadership remains in the hands of the government.
The principal tasks and functions of the Provincial and District/Municipal AIDS Commissions are as follows:

8.1. To lead, manage and coordinate HIV/ AIDS prevention activities in provinces, districts and municipalities.

8.2. To identify locations/ areas where there is potential for HIV/AIDS to spread, and initiate follow-up measures.

8.3. To collect, mobilize, and/ or exploit the resources from central, local, community or even international sources effectively and efficiently.

8.4. To develop information centres on the HIV/ AIDS program.

8.5. To encourage the establishment of local AIDS NGOs.

8.6. To provide technical guidance on HIV/ AIDS prevention to the related agencies at the provincial and district/ municipal levels as well as local NGOs.

8.7. To monitor and evaluate the implementation of HIV/ AIDS prevention programs in the region and take follow-up action where necessary.

9. COMMUNITY-BASED AND NONGOVERNMENTAL ORGANIZATIONS
NGOs and community-based organizations (CBOs) play a key role in HIV/AIDS prevention in Indonesia by reaching people and groups with specific needs-youth, faith-based groups, women, professionals, and PLHA, for example-that are often not easily reached by the government. Their activities include outreach, training, mentoring for PLHA, giving support, and counseling. NGOs and CBOs also play a part in motivating PLHA to establish self-help groups to provide mutual support and enable them to become more involved in HIV/ AIDS prevention.

10. PRIVATE SECTOR/ BUSINESS COMMUNITY
As an equal partner in national HIV/ AIDS prevention efforts, the private sector/business community plays a vital role in accelerating and expanding the coverage of prevention efforts in the work environment and by providing funds, facilities, specialists and so on.
The majority of Indonesia's workforce is employed in the private sector. Many types of employment and workplaces are potentially risky environments for exposure to HIV. Management and labour unions should therefore be encouraged to put in place HIV/AIDS prevention programs for their employees and others in their vicinity. Existing health and safety at work programs for employees should also cover HIV/ AIDS. Efforts to establish an enabling environment such as legislation for the organization of prevention in the workplace, should be intensified and expanded.

11. PROFESSIONALS, PROFESSIONAL ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS
Professionals, both individually and through their professional organizations or academic institutions, are urgently needed for their input into policy formulation, research, and evaluation of HIV/AIDS prevention activities.

12. THE COMMUNITY
The primary role of the community is to support the efforts of the government and AIDS concern groups in the prevention of HIV/ AIDS in their own environment.

12.1. Households and Families
The family unit plays a key social role in instilling principles of healthy behaviour and by being responsible for providing support for PLHA in the family.
As the smallest societal units, families need to become more cohesive and resilient in order to prevent the spread of HIV and to break down discriminatory attitudes against PLHA.

12.2. The Wider Community
The community must have access to clear and accurate information so that it can help to prevent HIV transmission and participate actively in HIV/AIDS prevention, and create a supportive environment for PLHA and their families.

13. PEOPLE LIVING WITH HIV/AIDS (PLHA)
Greater Involvement of People with AIDS (GIPA) can reduce stigma and discrimination.
PLHA can play an active role in HIV/ AIDS prevention by, for example, doing outreach through peer education, mentoring others, or becoming role models by remaining in their chosen field of employment. Apart from this, PLHA have a responsibility to prevent the transmission of HIV to their partners or other people.

INTERNATIONAL COOPERATION
International cooperation is a key component in building a response to the HIV/AIDS problem. Bilateral, regional, and global cooperation have already yielded significant contributions.
Cooperative ventures have already been developed at regional level, especially with ASEAN countries, on capacity building, program implementation, and technical assistance. Financial assistance, in the form of both loans and grants from donor countries, international organizations and international NGOs, has supported the implementation of several HIV/AIDS programs.
There will continue to be a need for aid to support the execution of the 2003 - 2007 National Strategy. International cooperation, will be needed on the development of HIV/AIDS information technology and networks, the supply of antiretroviral medications, research, and on seeking solutions to cross-border HIV/ AIDS problems.
Financial aid from international organizations for HIV/AIDS prevention is coordinated by the National AIDS Commission so that it can be utilized in accordance with the National HIV/ AIDS Strategy.

IMPLEMENTATION OF THE NATIONAL STRATEGY
The national HIV/ AIDS strategy should be implemented in a manner consistent with the policy goals that are to be achieved, and in response to the local epidemiological situation and conditions. To coordinate program implementation between the parties involved, the National AIDS Commission will make annual work plans and Five Year Plans for each priority area.
The work plans drawn up by the National AIDS Commission are introduced to all the parties involved at national, provincial and district/municipal levels to be used as a reference by these parties when they formulate their own work plans.
The National HIV/AIDS Strategy will be implemented in line with national development plans, and likewise at provincial, district and municipal levels in accordance with regional development plans.

MONITORING AND EVALUATION
To ensure that the stipulated objectives of HIV/ AIDS prevention activities are met, monitoring and evaluation are required.
Regular monitoring and evaluation carried out according to stipulated procedures can (i) help to ensure that HIV/ AIDS prevention programs achieve a high level of efficiency, (ii) help intensify and improve program implementation, (iii) allow for appropriate corrective action to direct the program, and (iv) yield other valuable information for program managers.
A set of monitoring and evaluation guidelines should be formulated to ensure that this activity proceeds effectively and efficiently.

FUNDING
Carrying out an HIV/AIDS program requires substantial funds. Funding for HIV/AIDS prevention comes from the central government, regional governments, the community/private sector and foreign aid-best given in the form of grants or soft loans.
Overseas aid, whether bilateral or multilateral, that is not conditional is nevertheless expected to be used proportionally to meet the needs of both the government and NGOs, in the most effective and efficient way possible.
The community including the private sector/ business community-should also be involved in fundraising at national and regional levels. The National AIDS Commission as well as Provincial and District/ Municipal AIDS Commissions can take initiatives to mobilize the public and the private sector/business community in collecting funds.

CONCLUSION
This National Strategy is the actualisation of the nation's commitment to confronting the increasingly serious threat of HIV/ AIDS, in order to safeguard the progression and success of national development. Moreover, the Indonesian nation, as a member of the world community, has a responsibility to contribute to the global response to HIV/AIDS.
It is a difficult and challenging task, but Indonesia has a wealth of experience to draw on in mobilizing the nation for the common interest. With the best effort of every member of this nation, we are confident that Indonesia will be able to contain the threat of HIV/AIDS for the sake of present and future generations.

ANNEX 1
Diagram Departmental and Non-departmental Roles and Responsibilities on HIV/AIDS

Coordinating Minister for People' s Welfare	Ministry of Women's Empowerment Pemberdayaan	State Minister of Information and Communication	Ministry of Tourism	Ministry of Home Affairs	Ministry of Foreign Affairs	Ministry of Defence
National Policy	Women's Empowerment	Public Information	Tourist Industry	Domestic Policy	International Cooperation	Uniformed Services
Coordinating the development of HIV/AIDS prevention policies Advocacy Coordinating planning, implementation and evaluation Coordinating the discussion of key issues HIV/AIDS data and information centre Managing intersectoral cooperation on HIV/AIDS policy	Integration of HIV/AIDS into the development of women's programs, including gender equity, and empowerment of women and girls	Media policies on HIV/AIDS Dissemination of HIV/AIDS information in government/private sector media at both local and international levels	Collaboration with the tourist industry on HIV/AIDS prevention programs	Policies on decentralization and resource allocation at central, province and district/municipal levels Supporting participation in combating stigmatization and discrimination	Coordinating government activities at national and international levels Regional and international HIV/AIDS information networks	HIV/AIDS prevention policies for the uniformed services and their communities Prevention, care and treatment for military personnel

Ministry of Finance	Ministry of Justice & Human Rights	Ministry of Industry & Trade	Ministry of Communications	Ministry of Education	Ministry of Health	Ministry of Religious Affairs
Resource Allocation	Legal Environment	Commercial Policy	Transport Policy	Prevention Education	Health Program	Faith-based Approach

Allocation of funds Disbursement systems for HIV/AIDS funds	Legal reform to protect human rights in the workplace Protection, care and treatment in detention/correctional facilities Legal and human rights reform on HIV/AIDS NGO Law to promote PWHA response	Price and trade policies for HIV/AIDS products Intellectual property provisions for domestic HIV/AIDS products Integration of HIV/AIDS into impact assessments of major industrial developments and free trade zones	Transport sector-based HIV/AIDS prevention campaigns	Health education curriculum (including youth and gender) Youth AIDS awareness prevention education policy in school-based and non school-based education HIV/AIDS prevention programs for tertiary education students HIV/AIDS prevention programs for educators	Care and treatment programs Health service systems HIV/AIDS prevention program HIV/AIDS and STI surveillance Coordination of IDU harm reduction program Healthy lifestyles information program	HIV/AIDS prevention education curriculum in religious schools and education centres Sermon-based HIV/AIDS prevention program f HIV/AIDS prevention through enhancement of spiritual life

Ministry of Manpower & Transmigration	Ministry of Social Welfare	National Development Planning Agency	Food & Drug Administration	National Family Planning Board	National Narcotics Agency	Ministry of Agriculture
World of Work & Transmigrant	Social Welfare	Socio-economic Development	Quality Control	Family Support	Drug Control	Agricultural Policy
AIDS policy/ regulations in the workplace Creating control programs in the world of work Improving policies on migrant populations and conflict areas Awareness raising in the world of work	Social support for people affected by HIV/AIDS Programs for vulnerable groups Counseling programs Social support for people in conflict areas	Integration of HIV/AIDS into national development plans Integration of HIV/AIDS programs into poverty reduction strategies	Systems for procurement and quality control of condoms, reagents, and f Anti-retroviral (ARV) drugs	Family empowerment f Information, Education and Communication (IEC) Reproductive Health Youth Reproductive Health	Coordinated response to the impact of HIV/AIDS transmission among IDUs	Making use of agricultural extension workers in HIV/AIDS prevention efforts Policies to prevent negative socio-economic impact of HIV/AIDS

ANNEX 2 ABBREVIATIONS AND TECHNICAL TERMS

AIDS: Acquired Immunodeficiency Syndrome. The end stage of infection caused by HIV, when the body's immune system is seriously damaged, making it vulnerable to common infections that can cause death.

ARV: Antiretroviral drugs/ therapy. Drugs used to treat a retrovirus such as HIV to slow its progress.

ASEAN: Association of Southeast Asian Nations

CBO: Community-based organization. An organization of individuals within a particular community that provides social services to members of that community.

Concentrated: A situation where there is less than 1 % prevalence Epidemic of HIV in the general population but in excess of 5 % in high-risk groups.

DKI Jakarta: Daerah Khusus Ibukota Jakarta. The Capital District of Jakarta, equivalent in status to a province.

Harm Reduction: Reducing the harmful consequences of injection drug use through, for example education of IDUs, needle and syringe exchange, and drug treatment and substitution programs.

HIV: Human Immunodeficiency Virus. The virus that causes AIDS by damaging the body's immune system.

HIV Positive: HIV antibodies have been detected in the blood, meaning that the person has been infected with HIV.

IDU: Injecting Drug User. A person who uses needles and syringes to inject illicit drugs.

IEC: Information, Education and Communication. The conveying of particular messages -e. g. on prevention, or reducing discrimination to specific target groups with the aim of changing their behaviour.

KPA: Komisi Penanggulangan AIDS: The National AIDS Commission.

KPAD : Komisi Penaggulangan AIDS Daerah: Regional AIDS Commission.

NGO : Nongovernmental organization. A private organization that work to promote the interests of the poor or disadvantaged, provide basic social service, undertake community development, protect the environment, etc.

100 % Condom: A program to prevent the spread of HIV infection among sex workers, their clients and the general population by getting owners and managers of entertainment establishments to enforce the use of condoms for commercial sex.

Opportunistic Infection: An infection that normally would not occur or become active if body's immune system was not weakened

Outreach: The delivery of prevention messages, materials and referrals to support services to certain groups whose behaviour or environment puts them at risk of exposure to HIV.

PMTCT: Prevention of mother-to-child transmission. Measures to prevent transmission of HIV from mother to infants during pregnancy, delivery and breastfeeding. Measures may include ARV therapy, breast milk substitution, and VCT.

PLHA: Person/people living with HIV/AIDS.

Risky Behaviour: Behaviour that significantly contributes to a person's risk of being infected with HIV, such as having sex without using a condom, or injecting drugs using shared or unsterilized needles.

STI: Sexually transmissible infection. An Infection that can be transmitted through unprotected sex with an infected partner. STIs include HIV, chlamydia, hepatitis B, syphilis, genorrhoea etc.

Surveillance: Repeated data collection from populations at high risk of HIV infection, to detect trends over time in behaviour or the distribution of HIV and STI.

UNAIDS: Joint Unites Nations Program on HIV/AIDS.

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

UNGASS: United Nations General Assembly Special Session (in this document, UNGASS' refers the Special Session on HIV/AIDS in 2001)

UNICEF: United Nations Children's Fund

Universal Precautions: Measures taken at hospitals, clinics, community health Precautions centres and so on to protect against exposure to diseases spread by blood and body fluids (such as HIV). Precautions include proper hygiene, wearing gloves, using disposable instruments, etc.

Unlinked and Anonymous Surveillance: Where individual test result are not linked to any information by which they can be identified and are not include on any medical records.

VCT: Voluntary Counseling and Testing. A combination of counseling and voluntary, confidential HIV testing where a person is counseled before the test so that they can make an informed choice a bout being tested, and after the test should they decide to take it.

WHO: World Health Organization.

BIBLIOGRAPHY

1. AIDS Division, Department of Communicable Disease Control, Ministry of Public Health, Thailand: National Plan for the Prevention and Alleviation of HIV/ AIDS in Thailand, 2000 - 2006.
2. ASEAN Secretariat: The ASEAN Work Programme HIV/ AIDS II (2002 - 2005)
3. AusAID: Compendium of Report, Asia Pacific Ministerial Meeting, Melbourne, 2001.
4. Kingdom of Cambodia, National AIDS Authority: National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/ AIDS 2001 - 2005.
5. Komisi Penanggulangan AIDS, Kantor Menteri Koordinator Kesejahteraan Rakyat, RI:
6. Laporan dan Rekomendasi untuk Revitalisasi Peran, Struktur dan Fungsi KPA dan Sekretariatnya. Jakarta, 2002.
7. Komisi Penanggulangan AIDS, Kantor Menteri Koordinator Kesejahteraan Rakyat, RI: Sidang Kabinet Sesi Khusus HIV/AIDS, Maret 2002. Respons saat ini, menangkal bencana Nasional AIDS mendatang. Jakarta, 2002.
8. Komisi Penanggulangan AIDS, Kantor Menteri Koordinator Kesejahteraan Rakyat, RI: Sidang Kabinet Khusus HIV/ AIDS, Desember 2002. Ancaman HIV/ AIDS di Indonesia. Semakin nyata, perlu penanggulangan lebih nyata. Jakarta, 2002.
9. Komisi Penanggulangan AIDS, Kantor Menteri Koordinator, RI: Strategi Nasional Penanggulangan AIDS di Indonesia 1994. Jakarta, 1994.
10. UNAIDS: Guide to the Strategic Planning Process for a National Response to HIV/AIDS. 1998.
11. UNAIDS: Implementing the Declaration of Commitment on HIV/ AIDS.
12. UNAIDS: Monitoring and Evaluation. Operation Manual.
13. UNAIDS: Summary of Declaration of Commitment on AIDS. UNGASS, 2001.
14. UNDP: Toward Borderless Strategies Against HIV/ AIDS. South East Asia, HIV and Development Programme. May 2002.

AD-HOC TEAM
THE DEVELOPMENT OF NATIONAL HIV/ AIDS STRATEGY 2003-2007

I. Steering Committee

Chairman : Dr. Farid W Husain, SpB, Kantor Menko Kesra

Vice Chairman : Prof Dr. Umar Fahmi Achmadi, MPH, Departemen Kesehatan

Secretary : Dr. Djoko Suharno, MPS, PhD, Kantor Menko Kesra

Members :
1. Dr. Haikin Rachmat, MSc, Departemen Kesehatan
2. Dr. Saiful Jazan, MSc, Departemen Kesehatan
3. Dr. Pudji Hastuti, MSc, Departemen Sosial
4. Dr. Widaninggar, M. Ed, Departemen Pendidikan Nasional
5. Chris W Green, Warta AIDS
6. Daniel Margueri, Yayasan Spiritia
7. Dr. Jane Wilson, UNAIDS
8. Farsida Lubis, UNDP
9. Kuspujiono, UNDP
10. Julia Loedin, UNDP
11. Dr. Stephen Wignall, ASA Project
12. Mr. Tim Mackay, AusAID
13. Abby Ruddick, PhD, AusAID
14. Dra. Retno Windrati, YPI
15. Husein Habsyi, YPI
16. Dra. Gelora Manurung, BKKBN
17. Drs. P. Supangkat, Depnakertrans

II. Consultants

1. Mr. Edward Reis
2. Dr. Broto Wasisto, MPH
3. Dr. Suharto, Sp Ko, DPH
4. Dr. Nadiar DTM, MPH

III. Supporting Team

Chairman: Drg. Naalih Kelsum, MPH, KPA

Members:
1. Dr. Chabib Afwan, KPA
2. Drs. A Suparman, KPA
3. Bagio Yulianto, UNDP